# Form 5500

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

### Annual Return/Report of Employee Benefit Plan

This form is required to be filed for employee benefit plans under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6057(b) and 6058(a) of the Internal Revenue Code (the Code).

▶ Complete all entries in accordance with the instructions to the Form 5500.

OMB Nos. 1210-0110 1210-0089

2017

Administration							
Pensio	n Benefit Guaranty Corporation				This	Form is Open to Pu Inspection	ublic
Part I	Annual Report Ide	entification Information					
For caler	ndar plan year 2017 or fisca	l plan year beginning 01/01/2017		and ending 12/31/20	)17		
A This r	eturn/report is for:	a multiemployer plan		loyer plan (Filers checking the nployer information in according the propertion in according the properties of the prope			ns.)
		x a single-employer plan	a DFE (specify)	)			
<b>B</b> This r	eturn/report is:	the first return/report	the final return/	•			
		an amended return/report		ar return/report (less than 12	•	)	
C If the	plan is a collectively-bargain	ned plan, check here				<b>•</b> []	
<b>D</b> Check	k box if filing under:	Form 5558	automatic exten	sion	the	e DFVC program	
		special extension (enter description)					
Part II	Basic Plan Inform	ation—enter all requested informatio	n				
1a Nam			_		1b	Three-digit plan	501
ZETA A	SSOCIATES INCORPORA	TED INDIVIDUAL BENEFIT ACCOUNT	Γ		4.0	number (PN) ▶	
						Effective date of plants o	
Maili	ng address (include room, a	, if for a single-employer plan) apt., suite no. and street, or P.O. Box) country, and ZIP or foreign postal code	(if foreign, see instru	uctions)	2b	Employer Identifica Number (EIN) 54-1279046	ation
ZETA AS	SOCIATES INCORPORAT	ED			2c Plan Sponsor's telephone number 703-385-7050		
SUITE 50	TON PLACE 10 , VA 22030				2d Business code (see instructions) 541700		
Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.							
	Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, as well as the electronic version of this return/report, and to the best of my knowledge and belief, it is true, correct, and complete.						
SIGN	Filed with authorized/valid e	electronic signature.	04/24/2018	SUE SUK	_		_
HERE	Signature of plan admini		Date	Enter name of individual si	igning as	plan administrator	

04/24/2018

Date

SUE SUK

For Paperwork Reduction Act Notice, see the Instructions for Form 5500.

Filed with authorized/valid electronic signature.

Signature of employer/plan sponsor

Signature of DFE

SIGN

**HERE** 

SIGN HERE

> Form 5500 (2017) v. 170203

Enter name of individual signing as employer or plan sponsor

Enter name of individual signing as DFE

	Form 5500 (2017)	Pa	nge <b>2</b>		
3a	Plan administrator's name and address X Same as Plan Sponsor			<b>3b</b> Administrator	's EIN
				3c Administrator number	's telephone
4	If the name and/or EIN of the plan sponsor or the plan name has changed sir enter the plan sponsor's name, EIN, the plan name and the plan number from			4b EIN	
a C	Sponsor's name Plan Name			4d PN	
5	Total number of participants at the beginning of the plan year			5	245
6	Number of participants as of the end of the plan year unless otherwise stated <b>6a(2)</b> , <b>6b</b> , <b>6c</b> , and <b>6d</b> ).	(welfare plans	s complete only lines 6a(1),		
a(	1) Total number of active participants at the beginning of the plan year			<mark>6a(1)</mark>	245
a(	2) Total number of active participants at the end of the plan year			6a(2)	231
b	Retired or separated participants receiving benefits			6b	
С	Other retired or separated participants entitled to future benefits			6с	
d	Subtotal. Add lines 6a(2), 6b, and 6c			6d	231
е	Deceased participants whose beneficiaries are receiving or are entitled to rec	ceive benefits.		6e	
f	Total. Add lines <b>6d</b> and <b>6e</b> .			6f	
g	Number of participants with account balances as of the end of the plan year (complete this item)			6g	
h	Number of participants who terminated employment during the plan year with less than 100% vested			6h	
7	Enter the total number of employers obligated to contribute to the plan (only r		<u>' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' </u>	•	
b	If the plan provides pension benefits, enter the applicable pension feature could be plan provides welfare benefits, enter the applicable welfare feature code 4A 4B 4D 4E 4F 4H 4I 4L	des from the Lis	st of Plan Characteristics Code	s in the instructions	
9a	Plan funding arrangement (check all that apply)  (1) Insurance	9b Plan be (1)	enefit arrangement (check all th	at apply)	
	(2) Code section 412(e)(3) insurance contracts	(2)	Code section 412(e)(3)	insurance contract	s
	(3) Trust	(3)	Trust		
10	(4) X General assets of the sponsor  Check all applicable boxes in 10a and 10b to indicate which schedules are at	(4)	General assets of the s  where indicated, enter the num	•	instructions)
	Pension Schedules		al Schedules	23. allaonoa. (000	
а	(1) R (Retirement Plan Information)	(1)	H (Financial Infor	mation)	
		(2)	H	mation – Small Plar	n)
	(2) MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan	(3)	X 6 A (Insurance Info		
	actuary	(4)	C (Service Provid	•	

(4) (5)

(6)

**SB** (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary

(3)

C (Service Provider Information)

**D** (DFE/Participating Plan Information)

**G** (Financial Transaction Schedules)

Part III	Form M-1 Compliance Information (to be completed by welfare benefit plans)					
11a If the plan provides welfare benefits, was the plan subject to the Form M-1 filing requirements during the plan year? (See instructions and 29 CFR 2520.101-2.)						
If "Ye	es" is checked, complete lines 11b and 11c.					
<b>11b</b> Is the	e plan currently in compliance with the Form M-1 filing requirements? (See instructions and 29 CFR 2520.101-2.)					
11c Enter the Receipt Confirmation Code for the 2017 Form M-1 annual report. If the plan was not required to file the 2017 Form M-1 annual report, enter the Receipt Confirmation Code for the most recent Form M-1 that was required to be filed under the Form M-1 filing requirements. (Failure to enter a valid Receipt Confirmation Code will subject the Form 5500 filing to rejection as incomplete.)						
Rece	eipt Confirmation Code					

Form 5500 (2017)

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Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

### **Insurance Information**

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

#### File as an attachment to Form 5500.

▶ Insurance companies are required to provide the information

OMB No. 1210-0110

pursuant to ERISA section 103(a)(2). Inspection								
For calendar plan ye	ar 2017 or fis	cal plar	n year beginning 01/01/2017		and en	ding 12/3	31/2017	
A Name of plan ZETA ASSOCIATES	S INCORPOR	RATED	INDIVIDUAL BENEFIT ACCOUN	Т		e-digit number (P	N) <b>•</b>	501
C Plan sponsor's na ZETA ASSOCIATES			e 2a of Form 5500		-	oyer Identific 1279046	cation Number	(EIN)
			rning Insurance Contract Lindividual contracts grouped as					
1 Coverage Informa	ation:							
(a) Name of insuran		RANCE	COMPANY AND AFFILIATES					
<b>/b</b> ) <b>F</b> INI	(c)	NAIC	(d) Contract or	(e) Approximate nu			Policy or c	ontract year
<b>(b)</b> EIN	co	de	identification number	persons covered a policy or contract		(f)	From	<b>(g)</b> To
59-1031071	67369		3334243	688	1	01/01/201	7	12/31/2017
2 Insurance fee and descending order			ation. Enter the total fees and tota	I commissions paid. Li	st in line 3	the agents,	brokers, and o	other persons in
(a) <sup>-</sup>	Total amount	of com	missions paid		<b>(b)</b> To	otal amount	of fees paid	
			153542					2221
3 Persons receiving	g commission	s and fe	ees. (Complete as many entries a	as needed to report all	persons).			
			and address of the agent, broker, o	or other person to whor	m commiss	ions or fees	were paid	
BB&T INSURANCE S	SERVICES IN	IC.		X 17370 SBORO, NC 27214				
(b) Amount of sa	les and hase		Fees	s and other commission	ns paid			
commissio			(c) Amount		(d) Purpose			(e) Organization code
131804		04	2221					3
	(a) l	Name a	and address of the agent, broker, o	or other person to whor	m commiss	ions or fees	were paid	
FBP INSURANCE SE	ERVICES		IRVINE, IRVINE,	CA 92602				
(b) Amount of sa	ales and haco		Fees	and other commission	ns paid			
commissio			(c) Amount		(d) Purpos	e		(e) Organization code
	198	31						
For Dononwork Dod	luction Act A	lotics	and the Instructions for Form Fl	500			Caha	dula A (Form 5500) 2017

Schedule A (Form 5500)	2017	Page <b>2</b> – 1	
(a) Nar	ne and address of the agent, broker	, or other person to whom commissions or fees were paid	
THE BENEFIT COMPANY INC.	P.O. B	SOX 29221 MBIA, SC 29221	
		Fees and other commissions paid	(e)
<b>(b)</b> Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
1907			
(a) Nar	ne and address of the agent, broker,	, or other person to whom commissions or fees were paid	
		Fees and other commissions paid	(e)
<b>(b)</b> Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
<b>(a)</b> Nar	ne and address of the agent, broker,	, or other person to whom commissions or fees were paid	
	l	Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
(a) Nar	ne and address of the agent, broker,	, or other person to whom commissions or fees were paid	
(b) Amount of calca and base	<u> </u>	Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
<b>(a)</b> Nar	ne and address of the agent, broker,	, or other person to whom commissions or fees were paid	

Fees and other commissions paid

(d) Purpose

(c) Amount

**(b)** Amount of sales and base commissions paid

(e) Organization code

F	Part	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual this report.	dual contracts wit	th each carrier may be trea	ted as a unit for purposes of
4	Curi	ent value of plan's interest under this contract in the general account at year	end	4	
5	Curi	rent value of plan's interest under this contract in separate accounts at year el	nd	5	
_		tracts With Allocated Funds:			•
	а	State the basis of premium rates •			
	b	Premiums paid to carrier		6b	
	С	Premiums due but unpaid at the end of the year		6c	
	d	If the carrier, service, or other organization incurred any specific costs in cor	nnection with the	acquisition or	
		retention of the contract or policy, enter amount			
		Specify nature of costs			
	е	Type of contract: (1) individual policies (2) group deferred	d annuity		
		(3) other (specify)			
		(c) [ cirior (opcomy) /			
	£	If anythrough anythrough in sub-plant in most to distribute boundite from a township	-ti	h	
7	f	If contract purchased, in whole or in part, to distribute benefits from a termin			
1		tracts With Unallocated Funds (Do not include portions of these contracts ma			
	а		te participation gu	uarantee	
		(3) guaranteed investment (4) other			
	b	Balance at the end of the previous year		7b	
	С	Additions: (1) Contributions deposited during the year	. 7c(1)		
		(2) Dividends and credits	. 7c(2)		
		(3) Interest credited during the year	. 7c(3)		
		(4) Transferred from separate account	7c(4)		
		(5) Other (specify below)	7c(5)		
		<b>)</b>			
		(6)Total additions		7c(6	) 0
	٦	(6)Total additions and additions (add lines <b>7b</b> and <b>7a(6)</b> )			,
		Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> )			
	е	Deductions: (1) Disbursed from fund to pay benefits or purchase annuities during year	70(1)		_
			7e(1)		
		(2) Administration charge made by carrier	7e(2)		
		(3) Transferred to separate account	7e(3)		
		(4) Other (specify below)	. /e(4)		_
		•			
		(5) Total deductions		7e(5	0
	f	Balance at the end of the current year (subtract line <b>7e(5)</b> from line <b>7d</b> )			

ı	Page	4

P	art I	Welfare Benefit Contract Informat If more than one contract covers the same gi the information may be combined for reportir employees, the entire group of such individual	oup of employees of the g purposes if such contra	acts are exp	perience-rated as a u	nit. Where co	ontracts cover in	
8	Done		di contracts with each car	nei may be	e treated as a drift for	puiposes oi t	піз тероп.	
O		efit and contract type (check all applicable boxes)	h V Dantal	ا م	V Vision		سرومان والم	
	a ×		<b>b</b> X Dental	-	X Vision		<b>d</b> Life insur	
	е	Temporary disability (accident and sickness)	f Long-term disability	g g	Supplemental uner	mployment	h X Prescript	on drug
	i	Stop loss (large deductible)	HMO contract	k	PPO contract		I X Indemnity	/ contract
	m	Other (specify)						
	_	_						
9	Expe	erience-rated contracts:	_					
	a F	Premiums: (1) Amount received		9a(1)		2977761		
		(2) Increase (decrease) in amount due but unpaid.		9a(2)				
		(3) Increase (decrease) in unearned premium rese	rve	9a(3)				
		(4) Earned ((1) + (2) - (3))	<u>.</u>		<u></u>	9a(4)		297776′
	b	Benefit charges (1) Claims paid		9b(1)		2384431		
		(2) Increase (decrease) in claim reserves		9b(2)		-82439	)	
		(3) Incurred claims (add (1) and (2))				9b(3)		2301992
		(4) Claims charged				9b(4)		2301992
	С	Remainder of premium: (1) Retention charges (on	an accrual basis)					
		(A) Commissions		9c(1)(A)		120511		
		(B) Administrative service or other fees		9c(1)(B)				
		(C) Other specific acquisition costs	-	9c(1)(C)				
		(D) Other expenses		9c(1)(D)		264297	<u>'</u>	
		(E) Taxes	-	9c(1)(E)		67893	<u> </u>	
		(F) Charges for risks or other contingencies	-	9c(1)(F)			_	
		(G) Other retention charges	_	9c(1)(G)		2 (4)(1)		45070
		(H) Total retention	_	_			1	45270
		(2) Dividends or retroactive rate refunds. (These a						223068
	d	Status of policyholder reserves at end of year: (1)	•			· · ·		
		(2) Claim reserves						374962
		(3) Other reserves				` '		
4.0		Dividends or retroactive rate refunds due. (Do not	include amount entered	in line 9c(2	<b>')</b> .)	9e		
10		nexperience-rated contracts:				- 40		
	а	Total premiums or subscription charges paid to ca	rrier			<u>10a</u>		1258468
		If the carrier, service, or other organization incurre				401-		
	Sner	retention of the contract or policy, other than repor cify nature of costs.	ted in Part I, line 2 above	, report am	ount	10b		
Р	art l	V Provision of Information						
11	Did	I the insurance company fail to provide any informa	tion necessary to comple	te Schedul	e A?	Yes	X No	<del></del>
12		ne answer to line 11 is "Yes," specify the informatio			<u>'</u>	_		

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

### **Insurance Information**

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

#### File as an attachment to Form 5500.

▶ Insurance companies are required to provide the information

OMB No. 1210-0110

pursuant to ERISA section 103(a)(2). Inspection							
For calendar plan year	2017 or fiscal plan	year beginning 01/01/2017	and e	nding 12/3	1/2017	_	
A Name of plan ZETA ASSOCIATES I	NCORPORATED	INDIVIDUAL BENEFIT ACCOUN	T	ee-digit n number (PN	N) <b>&gt;</b>	501	
C Plan sponsor's nam ZETA ASSOCIATES II		e 2a of Form 5500		D Employer Identification Number (EIN) 54-1279046			
		ning Insurance Contract . Individual contracts grouped as					
1 Coverage Information	on:						
(a) Name of insurance CIGNA GROUP INSUR							
	(c) NAIC	(d) Contract or	(e) Approximate number of		Policy or c	ontract year	
(b) EIN	code	identification number	persons covered at end of policy or contract year	(f)	From	<b>(g)</b> To	
23-1503749	65498	FLX963886		01/01/2017	7	01/01/2018	
2 Insurance fee and c descending order of		ation. Enter the total fees and tota	I commissions paid. List in line 3	the agents, l	brokers, and o	ther persons in	
<b>(a)</b> Tot	tal amount of comr		<b>(b)</b> T	otal amount	of fees paid		
		10080				5443	
3 Persons receiving c	ommissions and fe	ees. (Complete as many entries a	as needed to report all persons).				
	(a) Name a	nd address of the agent, broker, o	or other person to whom commis	sions or fees	were paid		
BB&T INSURANCE SE	RVICES INC.	P.O. BO RICHMO	X 17370 DND, VA 23226				
(b) Amount of sales	s and base	Fees	and other commissions paid				
commissions		(c) Amount	(d) Purpos	se	(e) Organization code		
10080		1411					
	(a) Name a	nd address of the agent, broker, o	or other person to whom commis	sions or fees	were paid		
THE BENEFIT COMPA		P.O. BO	X 211486 BIA, SC 29221				
(b) Amount of sales and base Fees and other commissions paid							
commissions		(c) Amount 4032	(d) Purpos	se		(e) Organization code	
						dula A /Farm FF00\ 2017	
	SELON AND MODERN	saa tha Instructions for Earm El			Caba		

Schedule A (Form 5500)	2017	Page <b>2 –</b> [	1	
(a) No.			aminaiana ar fana wara naid	
(a) Nai	me and address of the agent, broker	, or other person to whom con	nimissions or fees were paid	
4.1.		Fees and other commissions	paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code
(a) Na	me and address of the agent, broker	or other person to whom con	nmissions or fees were paid	
(-)		,		
(b) Amount of sales and base		Fees and other commissions p	paid	(e) Organization
commissions paid	(c) Amount	((	d) Purpose	code
<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
	<u> </u>			
(b) Amount of sales and base		Fees and other commissions p		(e) Organization
commissions paid	(c) Amount	(1	d) Purpose	code
<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
		Fees and other commissions p	naid	(e)
<b>(b)</b> Amount of sales and base commissions paid	(c) Amount		d) Purpose	Organization code
commissions paid		,		code
(1)				
( <b>a)</b> Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
All American Control		Fees and other commissions	paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code

F	Part	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual this report.	dual contracts wit	th each carrier may be trea	ted as a unit for purposes of
4	Curi	ent value of plan's interest under this contract in the general account at year	end	4	
5	Curi	rent value of plan's interest under this contract in separate accounts at year el	nd	5	
_		tracts With Allocated Funds:			•
	а	State the basis of premium rates •			
	b	Premiums paid to carrier		6b	
	С	Premiums due but unpaid at the end of the year		6c	
	d	If the carrier, service, or other organization incurred any specific costs in cor	nnection with the	acquisition or	
		retention of the contract or policy, enter amount			
		Specify nature of costs			
	е	Type of contract: (1) individual policies (2) group deferred	d annuity		
		(3) other (specify)			
		(c) [ cirior (opcomy) /			
	£	If anythrough anythrough in sub-plant in most to distribute boundite from a township	-ti	h	
7	f	If contract purchased, in whole or in part, to distribute benefits from a termin			
1		tracts With Unallocated Funds (Do not include portions of these contracts ma			
	а		te participation gu	uarantee	
		(3) guaranteed investment (4) other			
	b	Balance at the end of the previous year		7b	
	С	Additions: (1) Contributions deposited during the year	. 7c(1)		
		(2) Dividends and credits	. 7c(2)		
		(3) Interest credited during the year	. 7c(3)		
		(4) Transferred from separate account	7c(4)		
		(5) Other (specify below)	7c(5)		
		<b>)</b>			
		(6)Total additions		7c(6	) 0
	٦	(6)Total additions and additions (add lines <b>7b</b> and <b>7a(6)</b> )			,
		Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> )			
	е	Deductions: (1) Disbursed from fund to pay benefits or purchase annuities during year	70(1)		_
			7e(1)		
		(2) Administration charge made by carrier	7e(2)		
		(3) Transferred to separate account	7e(3)		
		(4) Other (specify below)	. /e(4)		_
		•			
		(5) Total deductions		7e(5	0
	f	Balance at the end of the current year (subtract line <b>7e(5)</b> from line <b>7d</b> )			

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Р	Part III Welfare Benefit Contract Information						
		If more than one contract covers the same the information may be combined for report employees, the entire group of such individ	ting purposes if such cont	racts are exp	erience-rated as a uni	t. Where co	ntracts cover individual
8	Ber	efit and contract type (check all applicable boxes)					
	а	Health (other than dental or vision)	<b>b</b> Dental	С	Vision		<b>d</b> X Life insurance
	е	Temporary disability (accident and sickness)	f Long-term disabilit	ty g	Supplemental unem		h Prescription drug
	:			·	<u>-</u>	pioymont	<b>=</b>
	• !	Stop loss (large deductible)	j HMO contract	k_	PPO contract		I Indemnity contract
	m	Other (specify)					
_	_						
9	•	erience-rated contracts:		0-(4)			
	а	Premiums: (1) Amount received		9a(1)			
		(2) Increase (decrease) in amount due but unpaid					
		(3) Increase (decrease) in unearned premium res				02(4)	
	b	(4) Earned ((1) + (2) - (3))				. 9a(4)	
		(2) Increase (decrease) in claim reserves		(-)			
		(3) Incurred claims (add (1) and (2))				. 9b(3)	
		(4) Claims charged				9b(4)	
	С	Remainder of premium: (1) Retention charges (o					
		(A) Commissions	•	9c(1)(A)			
		(B) Administrative service or other fees		- (1)(-)			
		(C) Other specific acquisition costs		9c(1)(C)			
		(D) Other expenses		9c(1)(D)			
		(E) Taxes					
		(F) Charges for risks or other contingencies.		9c(1)(F)			
		(G) Other retention charges		9c(1)(G)			
		(H) Total retention				9c(1)(H)	
		(2) Dividends or retroactive rate refunds. (These					
	d	Status of policyholder reserves at end of year: (1				. 9d(1)	
		(2) Claim reserves				. 9d(2)	
	_	(3) Other reserves				9d(3)	
40	е .	Dividends or retroactive rate refunds due. (Do no	ot include amount entered	d in line 9c(2)	.)	. 9e	
IU	_	nexperience-rated contracts:				. 10a	404050
	a	Total premiums or subscription charges paid to c				IUa	104953
	b	If the carrier, service, or other organization incurretention of the contract or policy, other than report				10b	
	Spe	cify nature of costs.	2.1.0 a a, a a a a a a	o, roport arri			
_	art	IV Provision of Information					
							V N.
11		d the insurance company fail to provide any inform		ete Schedule	e A?	Yes	X No
12	lf 1	he answer to line 11 is "Yes," specify the informati	ion not provided.				

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

### **Insurance Information**

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

#### File as an attachment to Form 5500.

OMB No. 1210-0110

► Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).				This Fo	rm is Open to Public Inspection			
For calendar plan year 20	17 or fiscal pla	an year beginning 01/01/2017		ar	nd ending 12/3	1/2017		
A Name of plan ZETA ASSOCIATES INC	ORPORATED	D INDIVIDUAL BENEFIT ACCOUN	IT		Three-digit plan number (PN	۷) 🕨	501	
C Plan sponsor's name a	as shown on li	ne 2a of Form 5500		D E	mployer Identific	ation Number	(EIN)	
ZETA ASSOCIATES INC					54-1279046		,	
		erning Insurance Contract A. Individual contracts grouped as						
1 Coverage Information:								
(a) Name of insurance ca								
/b) FIN	(c) NAIC	(d) Contract or	(e) Approximate nu persons covered at			Policy or o	contract year	
(b) EIN	code	identification number	policy or contract		(f)	From	<b>(g)</b> To	
23-1503749	65498	OK 965514			01/01/2017		01/01/2018	
2 Insurance fee and com descending order of the		nation. Enter the total fees and total	al commissions paid. Li	st in li	ne 3 the agents,	brokers, and	other persons in	
(a) Total amount of commissions paid (b) Total amount of fees paid								
		427					68	
3 Persons receiving com	missions and	fees. (Complete as many entries	as needed to report all p	persor	ns).			
		and address of the agent, broker,				were paid		
BB&T INSURANCE SERV	ICES INC.		OX 17370 OND, VA 23226					
(h) Amount of color of		Fee	s and other commission	ns paic	<u> </u>			
(b) Amount of sales au commissions pa		(c) Amount		(d) Purpose		(e) Organization code		
	427	68					3	
	(a) Name	and address of the agent, broker,	or other person to whor	n com	missions or fees	were paid		
(b) Amount of sales a	nd base	Fee	s and other commission	ns paid	d			
commissions pa		(c) Amount		<b>(d)</b> Pu	rpose		(e) Organization code	
							3	
For Donomically Dodinatio	n Aat Natica	see the Instructions for Form F	E00			Coho	dula A (Form 5500) 2017	

Schedule A (Form 5500)	2017	Page <b>2 –</b> [	1		
(a) No.			aminaiana ar fana wara naid		
(a) Nai	me and address of the agent, broker	, or other person to whom con	nimissions or lees were paid		
4.1.		Fees and other commissions	paid	(e)	
(b) Amount of sales and base commissions paid	(b) Amount of sales and base commissions paid (c) Amount (d) Purpose			Organization code	
(a) Na	me and address of the agent, broker	or other person to whom con	nmissions or fees were paid		
(-)		,			
(b) Amount of sales and base		Fees and other commissions p	paid	(e) Organization	
commissions paid	(c) Amount	((	code		
<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid		
	<u> </u>				
(b) Amount of sales and base		Fees and other commissions p		(e) Organization	
commissions paid	(c) Amount	(1	d) Purpose	code	
<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid		
		Fees and other commissions p	naid	(e)	
<b>(b)</b> Amount of sales and base commissions paid	(c) Amount		d) Purpose	Organization code	
commissions paid		,	<u>,                                      </u>	code	
(1)					
( <b>a)</b> Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid		
All American Control		Fees and other commissions	paid	(e)	
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code	

F	Part	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual this report.	dual contracts wit	th each carrier may be trea	ted as a unit for purposes of
4	Curi	ent value of plan's interest under this contract in the general account at year	end	4	
5	Curi	rent value of plan's interest under this contract in separate accounts at year el	nd	5	
_		tracts With Allocated Funds:			•
	а	State the basis of premium rates •			
	b	Premiums paid to carrier		6b	
	С	Premiums due but unpaid at the end of the year		6c	
	d	If the carrier, service, or other organization incurred any specific costs in cor	nnection with the	acquisition or	
		retention of the contract or policy, enter amount			
		Specify nature of costs			
	е	Type of contract: (1) individual policies (2) group deferred	d annuity		
		(3) other (specify)			
		(c) [ cirior (opcomy) /			
	£	If anythrough anythrough in sub-plant in most to distribute boundite from a township	-ti	h	
7	f	If contract purchased, in whole or in part, to distribute benefits from a termin			
1		tracts With Unallocated Funds (Do not include portions of these contracts ma			
	а		te participation gu	uarantee	
		(3) guaranteed investment (4) other			
	b	Balance at the end of the previous year		7b	
	С	Additions: (1) Contributions deposited during the year	. 7c(1)		
		(2) Dividends and credits	. 7c(2)		
		(3) Interest credited during the year	. 7c(3)		
		(4) Transferred from separate account	7c(4)		
		(5) Other (specify below)	7c(5)		
		<b>)</b>			
		(6)Total additions		7c(6	) 0
	٦	(6)Total additions and additions (add lines <b>7b</b> and <b>7a(6)</b> )			,
		Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> )			
	е	Deductions: (1) Disbursed from fund to pay benefits or purchase annuities during year	70(1)		_
			7e(1)		
		(2) Administration charge made by carrier	7e(2)		
		(3) Transferred to separate account	7e(3)		
		(4) Other (specify below)	. /e(4)		_
		•			
		(5) Total deductions		7e(5	0
	f	Balance at the end of the current year (subtract line <b>7e(5)</b> from line <b>7d</b> )			

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F	Part	III	Welfare Benefit Contract Information from the information may be combined for report employees, the entire group of such individuals.	group of employees of the ing purposes if such cont	racts are exp	erience-rated as a uni	t. Where co	ntracts cover inc	
8	Ben	efit a	nd contract type (check all applicable boxes)			·		•	
	а	٦нε	ealth (other than dental or vision)	<b>b</b> Dental	с	Vision		<b>d</b> Life insura	ance
	e	=	mporary disability (accident and sickness)	f Long-term disability	=	<u>-</u>	nlovmont	h Prescription	
		_		<b>=</b>		=	pioyinent	=	•
	ַ י		op loss (large deductible)	j HMO contract	K	PPO contract		I Indemnity	contract
	m	X Ot	her (specify) ACCIDENTAL DEATH						
9			ce-rated contracts:						
	a		iums: (1) Amount received		9a(1)				
			ncrease (decrease) in amount due but unpaid						
			ncrease (decrease) in unearned premium res				0-(4)		
	h	. ,	farned ((1) + (2) - (3))				. 9a(4)		
	b		efit charges (1) Claims paid		• •			_	
			ncrease (decrease) in claim reserves				0b/2)		
			ncurred claims (add (1) and (2))						
	•	` '	Claims charged(1) Retention charges (c			•••••	. 9b(4)		
	С			·	9c(1)(A)				
			(A) Commissions(B) Administrative service or other fees		- 4.114-1				
			(C) Other specific acquisition costs		9c(1)(C)				
			(D) Other expenses		9c(1)(D)				
			(E) Taxes		0.74\75\				
			(F) Charges for risks or other contingencies.						
			(G) Other retention charges		0.74\/0\				
			(H) Total retention				9c(1)(H)		
		(2) [	Dividends or retroactive rate refunds. (These	amounts were paid ir	cash, or	credited.)			
	d		us of policyholder reserves at end of year: (1		<u> </u>				
			Claim reserves				9d(2)		
		(3) (	Other reserves						
	е	Divi	dends or retroactive rate refunds due. (Do n	ot include amount entered	d in line <b>9c(2)</b>	.)	. 9e		
10	<b>)</b> No	nexp	erience-rated contracts:						
	а	Tota	al premiums or subscription charges paid to o	arrier			. 10a		427
	b		e carrier, service, or other organization incur ntion of the contract or policy, other than rep				. 10b		
		cify r	ature of costs.	offed in Part I, line 2 abov	e, report amo	ount	.( 100		
F	art l	IV	Provision of Information						
11	<b>l</b> Dic	the	insurance company fail to provide any inform	nation necessary to comp	ete Schedule	e A?	Yes	X No	
12	2 If t	he ar	swer to line 11 is "Yes," specify the informat	on not provided.					

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

### **Insurance Information**

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

#### File as an attachment to Form 5500.

▶ Insurance companies are required to provide the information

OMB No. 1210-0110

2017

This Form is Open to Public

		pursuant to E	ERISA section 103(a)(2)				Inspection	
For calendar plan year 20°	17 or fiscal plar	year beginning 01/01/2017		and en	ding 12/3	31/2017		
A Name of plan ZETA ASSOCIATES INCO	ORPORATED	INDIVIDUAL BENEFIT ACCOUN	NT	B Three-digit plan number (PN) ▶ 501			501	
C Plan sponsor's name a ZETA ASSOCIATES INCO		e 2a of Form 5500		-	yer Identific 1279046	ation Number (	EIN)	
		ning Insurance Contract  Individual contracts grouped as						
1 Coverage Information:								
(a) Name of insurance car CIGNA GROUP INSURAN								
	(c) NAIC	(d) Contract or	(e) Approximate nu			Policy or co	entract year	
<b>(b)</b> EIN	code	identification number	persons covered a policy or contract		(f)	From	<b>(g)</b> To	
23-1503749	65498	LK 750914			01/01/201	7	01/01/2018	
2 Insurance fee and coming descending order of the		ation. Enter the total fees and tot	al commissions paid. Li	ist in line 3	the agents,	brokers, and of	ther persons in	
(a) Total a	amount of comr	missions paid		<b>(b)</b> To	tal amount	of fees paid		
		7325					3793	
3 Persons receiving com	missions and fe	ees. (Complete as many entries	as needed to report all	persons).				
	<b>(a)</b> Name a	nd address of the agent, broker,	or other person to whor	m commiss	ions or fees	were paid		
BB&T INSURANCE SERV	ICES INC.		OX 17370 IOND, VA 23226					
(b) Amount of sales ar	nd hase	Fee	es and other commission	ns paid				
commissions pai		(c) Amount	(d) Purpose			(e) Organization code		
	7325	863						
	(a) Name a	nd address of the agent, broker,	or other person to whor	m commiss	ions or fees	were paid		
THE BENEFIT COMPANY	INC.		OX 211486 MBIA, SC 29221					
(b) Amount of sales and base Fees and other commissions paid								
commissions pai		(c) Amount		(d) Purpose			(e) Organization code	
		2930						
For Panerwork Reduction	n Act Notice	see the Instructions for Form 5	5500			Scher	lule A (Form 5500) 2017	

Schedule A (Form 5500)	2017	Page <b>2 –</b> [	1		
(a) No.			omicciono ar foco ware noid		
(a) Nai	me and address of the agent, broker	, or other person to whom con	nimissions or lees were paid		
4.1.		Fees and other commissions	paid	(e)	
(b) Amount of sales and base commissions paid	(b) Amount of sales and base commissions paid (c) Amount (d) Purpose			Organization code	
(a) Na	me and address of the agent, broker	or other person to whom con	nmissions or fees were paid		
(-)		,			
(b) Amount of sales and base		Fees and other commissions p	paid	(e) Organization	
commissions paid	(c) Amount	((	code		
<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid		
	<u> </u>				
(b) Amount of sales and base		Fees and other commissions p		(e) Organization	
commissions paid	(c) Amount	(1	d) Purpose	code	
<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid		
		Fees and other commissions p	naid	(e)	
<b>(b)</b> Amount of sales and base commissions paid	(c) Amount		d) Purpose	Organization code	
commissions paid		,	<u>,                                      </u>	code	
(1)					
( <b>a)</b> Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid		
All American Control		Fees and other commissions	paid	(e)	
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code	

F	Part	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual this report.	dual contracts wit	th each carrier may be trea	ted as a unit for purposes of
4	Curi	ent value of plan's interest under this contract in the general account at year	end	4	
5	Curi	rent value of plan's interest under this contract in separate accounts at year el	nd	5	
_		tracts With Allocated Funds:			•
	а	State the basis of premium rates •			
	b	Premiums paid to carrier		6b	
	С	Premiums due but unpaid at the end of the year		6c	
	d	If the carrier, service, or other organization incurred any specific costs in cor	nnection with the	acquisition or	
		retention of the contract or policy, enter amount			
		Specify nature of costs			
	е	Type of contract: (1) individual policies (2) group deferred	d annuity		
		(3) other (specify)			
		(c) [ cirior (opcomy) /			
	£	If anythrough anythrough in sub-plant in most to distribute boundite from a town-in-	-ti	h	
7	f	If contract purchased, in whole or in part, to distribute benefits from a termin			
1		tracts With Unallocated Funds (Do not include portions of these contracts ma			
	а		te participation gu	uarantee	
		(3) guaranteed investment (4) other			
	b	Balance at the end of the previous year		7b	
	С	Additions: (1) Contributions deposited during the year	7c(1)		
		(2) Dividends and credits	. 7c(2)		
		(3) Interest credited during the year	. 7c(3)		
		(4) Transferred from separate account	7c(4)		
		(5) Other (specify below)	7c(5)		
		<b>)</b>			
		(6)Total additions		7c(6	) 0
	٦	(6)Total additions and additions (add lines <b>7b</b> and <b>7a(6)</b> )			,
		Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> )			
	е	Deductions: (1) Disbursed from fund to pay benefits or purchase annuities during year	70(1)		_
			7e(1)		
		(2) Administration charge made by carrier	7e(2)		
		(3) Transferred to separate account	7e(3)		
		(4) Other (specify below)	. /e(4)		_
		•			
		(5) Total deductions		7e(5	0
	f	Balance at the end of the current year (subtract line <b>7e(5)</b> from line <b>7d</b> )			

ı	Page	4

P	art l	III Welfare Benefit Contract Information	tion					
		If more than one contract covers the same g the information may be combined for reportir employees, the entire group of such individu	ng purposes if such cont	racts are exp	erience-rated as a uni	t. Where co	ontracts cover individual	
8	Bene	nefit and contract type (check all applicable boxes)		-	<u> </u>	-	·	
	а		<b>b</b> Dental	с	Vision		<b>d</b> Life insurance	
	e D		f  Long-term disabilit	<u> </u>	Supplemental unem	nlovmont	h Prescription drug	
	. r			· - =	<u>-</u>	pioyment		
	י ו	Stop loss (large deductible)	j HMO contract	k_	PPO contract		I Indemnity contract	
	m	Other (specify)						
9	Expe	erience-rated contracts:	1					
		Premiums: (1) Amount received		9a(1)				
		(2) Increase (decrease) in amount due but unpaid.						
		(3) Increase (decrease) in unearned premium rese	· ·			2 (1)		
	_	(4) Earned ((1) + (2) - (3))				. 9a(4)		
	b	Benefit charges (1) Claims paid						
		(2) Increase (decrease) in claim reserves	· ·			01- (0)		
		(3) Incurred claims (add (1) and (2))				9b(3)		
		(4) Claims charged		•••••		. 9b(4)		
	С	Remainder of premium: (1) Retention charges (on		0c(1)(A)				
		(A) Commissions(B) Administrative service or other fees		9c(1)(A) 9c(1)(B)				
		(C) Other specific acquisition costs		9c(1)(C)				
		(D) Other expenses		0 (4)(D)				
		(E) Taxes						
		(F) Charges for risks or other contingencies		9c(1)(F)				
		(G) Other retention charges		9c(1)(G)				
		(H) Total retention	•			9c(1)(H)	)	
		(2) Dividends or retroactive rate refunds. (These a	amounts were paid in	cash, or	credited.)	9c(2)		
	d	Status of policyholder reserves at end of year: (1)		_		9d(1)		
		(2) Claim reserves	·			. 9d(2)		
		(3) Other reserves				9d(3)		
	е	Dividends or retroactive rate refunds due. (Do not	t include amount entered	d in line <b>9c(2)</b>	.)	. 9e		
10	No	onexperience-rated contracts:				1		
	а	Total premiums or subscription charges paid to ca	rrier			. 10a	7.	3254
	b	If the carrier, service, or other organization incurre retention of the contract or policy, other than report			•	10b		
	Spe	retention of the contract or policy, other than report ecify nature of costs.	fted in Part I, line 2 abov	e, report amo	ount	. <u>  10b</u>	.1	
_								
P	art l	IV Provision of Information						
11	Dic	d the insurance company fail to provide any informa	ation necessary to compl	ete Schedule	e A?	Yes	X No	
12	lf tl	the answer to line 11 is "Yes," specify the information	n not provided.					

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

### **Insurance Information**

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

#### File as an attachment to Form 5500.

▶ Insurance companies are required to provide the information

OMB No. 1210-0110

		pursuant to El	RISA section 103(a)(2).			Inspection	
For calendar plan year 20°	17 or fiscal plan	year beginning 01/01/2017	a	nd ending 12/	31/2017		
A Name of plan ZETA ASSOCIATES INCOME.	ORPORATED I	INDIVIDUAL BENEFIT ACCOUN	В	Three-digit plan number (P	PN) •	501	
C Plan sponsor's name a ZETA ASSOCIATES INCO	D	Employer Identifi 54-1279046	cation Number (	EIN)			
		ning Insurance Contract . Individual contracts grouped as					
1 Coverage Information:							
(a) Name of insurance car CIGNA GROUP INSURAN							
/b) [IN	(c) NAIC	(d) Contract or	(e) Approximate number		Policy or co	ontract year	
<b>(b)</b> EIN	code	identification number	persons covered at end policy or contract year	(1	) From	<b>(g)</b> To	
23-1503749 65498 LK 962754			01/01/20	17	01/01/2018		
2 Insurance fee and compute descending order of the		ation. Enter the total fees and tota	I commissions paid. List in	line 3 the agents	, brokers, and ot	her persons in	
(a) Total amount of commissions paid (b) Total amount of fees paid							
		15561				8684	
3 Persons receiving com	missions and fe	ees. (Complete as many entries a	as needed to report all perso	ons).			
		nd address of the agent, broker, o	•	nmissions or fee	s were paid		
BB&T INSURANCE SERV	ICES INC.		X 17370 DND, VA 23226				
(b) Amount of sales ar	nd base	Fees	and other commissions pa	id			
commissions pai		(c) Amount	(d) Purpose			(e) Organization code	
	15561	2460					
	(a) Name a	nd address of the agent, broker, o	or other person to whom cor	nmissions or fee	s were paid		
THE BENEFIT COMPANY		P.O. BO	X 211486 BIA, SC 29221		o word para		
<b>(b)</b> Amount of sales ar	nd base	Fees	and other commissions pa	id			
commissions pai		(c) Amount	•	urpose		(e) Organization code	
		6224					
For Paperwork Reductio	n Act Notice, s	see the Instructions for Form 55	500.		Sched	lule A (Form 5500) 2017	

Schedule A (Form 5500)	2017	Page <b>2 –</b> [	1	
(a) No.			omicciono ar foco ware noid	
(a) Nai	me and address of the agent, broker	, or other person to whom con	nimissions or lees were paid	
4.1.		Fees and other commissions	paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code
(a) Na	me and address of the agent, broker	or other person to whom con	nmissions or fees were paid	
(-)		,		
(b) Amount of sales and base		Fees and other commissions p	paid	(e) Organization
commissions paid	(c) Amount	((	d) Purpose	code
<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
	<u> </u>			
(b) Amount of sales and base		Fees and other commissions p		(e) Organization
commissions paid	(c) Amount	(1	d) Purpose	code
<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
		Fees and other commissions p	naid	(e)
<b>(b)</b> Amount of sales and base commissions paid	(c) Amount		d) Purpose	Organization code
commissions paid		,		code
(1)				
( <b>a)</b> Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
All American Control		Fees and other commissions	paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code

F	Part	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual this report.	dual contracts wit	th each carrier may be trea	ted as a unit for purposes of
4	Curi	ent value of plan's interest under this contract in the general account at year	end	4	
5	Curi	rent value of plan's interest under this contract in separate accounts at year el	nd	5	
_		tracts With Allocated Funds:			•
	а	State the basis of premium rates •			
	b	Premiums paid to carrier		6b	
	С	Premiums due but unpaid at the end of the year		6c	
	d	If the carrier, service, or other organization incurred any specific costs in cor	nnection with the	acquisition or	
		retention of the contract or policy, enter amount			
		Specify nature of costs			
	е	Type of contract: (1) individual policies (2) group deferred	d annuity		
		(3) other (specify)			
		(c) [ cirior (opcomy) /			
	£	If anythrough anythrough in sub-plant in most to distribute boundite from a town-in-	-ti	h	
7	f	If contract purchased, in whole or in part, to distribute benefits from a termin			
1		tracts With Unallocated Funds (Do not include portions of these contracts ma			
	а		te participation gu	uarantee	
		(3) guaranteed investment (4) other			
	b	Balance at the end of the previous year		7b	
	С	Additions: (1) Contributions deposited during the year	7c(1)		
		(2) Dividends and credits	. 7c(2)		
		(3) Interest credited during the year	. 7c(3)		
		(4) Transferred from separate account	7c(4)		
		(5) Other (specify below)	7c(5)		
		<b>)</b>			
		(6)Total additions		7c(6	) 0
	٦	(6)Total additions and additions (add lines <b>7b</b> and <b>7a(6)</b> )			,
		Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> )			
	е	Deductions: (1) Disbursed from fund to pay benefits or purchase annuities during year	70(1)		_
			7e(1)		
		(2) Administration charge made by carrier	7e(2)		
		(3) Transferred to separate account	7e(3)		
		(4) Other (specify below)	. /e(4)		_
		•			
		(5) Total deductions		7e(5	0
	f	Balance at the end of the current year (subtract line <b>7e(5)</b> from line <b>7d</b> )			

ı	Page	4

F	art	Welfare Benefit Contract Informa If more than one contract covers the same of the information may be combined for reportifient employees, the entire group of such individual	group of employees of the ing purposes if such contr	acts are ex	perience-rated as a u	unit. Where co	ontracts cover individual
8	Ben	efit and contract type (check all applicable boxes)					
	а	Health (other than dental or vision)	<b>b</b> Dental	С	Vision		<b>d</b> Life insurance
	е	Temporary disability (accident and sickness)	f Long-term disability	v a	Supplemental une	employment	h Prescription drug
	; [	Stop loss (large deductible)	j HMO contract	k		Jp.10 J	I Indemnity contract
	' [		I I I I I I I I I I I I I I I I I I I	N	11 O contract		I I Indemnity contract
	m	Other (specify)					
^	<u></u>						
9		erience-rated contracts:	Г	00/1)			_
	а	Premiums: (1) Amount received(2) Increase (decrease) in amount due but unpaid	l l	9a(1) 9a(2)			_
		(3) Increase (decrease) in unearned premium resi	The state of the s	9a(2)			_
		(4) Earned ((1) + (2) - (3))	-			9a(4)	
	b	Benefit charges (1) Claims paid	T T	9b(1)		Ju(+)	
		(2) Increase (decrease) in claim reserves	•	9b(2)			_
		(3) Incurred claims (add <b>(1)</b> and <b>(2)</b> )	_			9b(3)	
		(4) Claims charged					
	С	Remainder of premium: (1) Retention charges (or					
		(A) Commissions	· · · · · · · · · · · · · · · · · · ·	9c(1)(A)			
		(B) Administrative service or other fees		9c(1)(B)			
		(C) Other specific acquisition costs		9c(1)(C)			
		(D) Other expenses		9c(1)(D)			
		(E) Taxes		9c(1)(E)			
		(F) Charges for risks or other contingencies		9c(1)(F)			
		(G) Other retention charges		9c(1)(G)		1	
		(H) Total retention				9c(1)(H)	
		(2) Dividends or retroactive rate refunds. (These	amounts were paid in	cash, or	credited.)	9c(2)	
	d	Status of policyholder reserves at end of year: (1)	Amount held to provide I	penefits afte	er retirement	9d(1)	
		(2) Claim reserves					
		(3) Other reserves				` ` `	
	е	Dividends or retroactive rate refunds due. (Do no	t include amount entered	in line 9c(2	2 <b>)</b> .)	9e	
10	) No	nexperience-rated contracts:					
	а	Total premiums or subscription charges paid to ca	arrier			<u>10a</u>	15560
	b	If the carrier, service, or other organization incurreretention of the contract or policy, other than reposits potters of costs.					
		cify nature of costs.					
P	art	V Provision of Information					
11	Die	the insurance company fail to provide any inform	ation necessary to comple	ete Schedu	le A?	Yes	X No
12	2 If t	he answer to line 11 is "Yes," specify the information	on not provided.				

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

### **Insurance Information**

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

#### File as an attachment to Form 5500.

OMB No. 1210-0110

	, , , , , ,		ERISA section 103(a)(2).	e morman	ion	This Fo	rm is Open to Public Inspection
For calendar plan year 20	17 or fiscal pla	n year beginning 01/01/2017		and en	ding 12/31	/2017	
A Name of plan ZETA ASSOCIATES INC	ORPORATED	INDIVIDUAL BENEFIT ACCOU	TAIL		e-digit number (PN)	) <b>&gt;</b>	501
C Plan sponsor's name a ZETA ASSOCIATES INCO	ORPORATED			54-	oyer Identifica 1279046		
		rning Insurance Contract  A. Individual contracts grouped					
1 Coverage Information:							
(a) Name of insurance ca CIGNA GROUP INSURAN						D 11	
<b>(b)</b> EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate null persons covered at		(f)	Policy or o	contract year
			policy or contract	year		FIOIII	<b>(g)</b> To
23-1503749	65498	TDI960459			01/01/2017		01/01/2018
2 Insurance fee and communication descending order of the		nation. Enter the total fees and to	otal commissions paid. Lis	st in line 3 t	the agents, b	rokers, and	other persons in
(a) Total a	amount of com	nmissions paid		<b>(b)</b> To	otal amount o	f fees paid	
		26					9
3 Persons receiving com	missions and f	fees. (Complete as many entrie	s as needed to report all p	ersons).			
	(a) Name a	and address of the agent, broke	r, or other person to whom	n commissi	ions or fees v	were paid	
BB&T INSURANCE SERV	ICES INC.		BOX 17380 MOND, VA 23226				
(b) Amount of sales ar	nd base	Fe	ees and other commission	s paid			
commissions pai	d	(c) Amount		d) Purpose	е		(e) Organization code
	26	9					
	(a) Name a	and address of the agent, broke	r, or other person to whom	n commissi	ions or fees v	vere paid	
	,,					·	
(b) Amount of sales ar	nd base	Fe	ees and other commission	s paid			
commissions pai		(c) Amount		<b>d)</b> Purpose	е		(e) Organization code

Schedule A (Form 5500)	2017	Page <b>2 –</b> [	1	
(a) No.			omicciono ar foco ware noid	
(a) Nai	me and address of the agent, broker	, or other person to whom con	nimissions or lees were paid	
4.1.		Fees and other commissions	paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code
(a) Na	me and address of the agent, broker	or other person to whom con	nmissions or fees were paid	
(-)		,		
(b) Amount of sales and base		Fees and other commissions p	paid	(e) Organization
commissions paid	(c) Amount	((	d) Purpose	code
<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
	<u> </u>			
(b) Amount of sales and base		Fees and other commissions p		(e) Organization
commissions paid	(c) Amount	(1	d) Purpose	code
<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
		Fees and other commissions p	naid	(e)
<b>(b)</b> Amount of sales and base commissions paid	(c) Amount		d) Purpose	Organization code
commissions paid		,	<u>,                                      </u>	code
(1)				
( <b>a)</b> Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
All American Control		Fees and other commissions	paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code

F	Part	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual this report.	dual contracts wit	th each carrier may be trea	ted as a unit for purposes of
4	Curi	ent value of plan's interest under this contract in the general account at year	end	4	
5	Curi	rent value of plan's interest under this contract in separate accounts at year el	nd	5	
_		tracts With Allocated Funds:			•
	а	State the basis of premium rates •			
	b	Premiums paid to carrier		6b	
	С	Premiums due but unpaid at the end of the year		6c	
	d	If the carrier, service, or other organization incurred any specific costs in cor	nnection with the	acquisition or	
		retention of the contract or policy, enter amount			
		Specify nature of costs			
	е	Type of contract: (1) individual policies (2) group deferred	d annuity		
		(3) other (specify)			
		(c) [ cirior (opcomy) /			
	£	If anythrough anythrough in sub-plant in most to distribute boundite from a town-in-	-ti	h	
7	f	If contract purchased, in whole or in part, to distribute benefits from a termin			
1		tracts With Unallocated Funds (Do not include portions of these contracts ma			
	а		te participation gu	uarantee	
		(3) guaranteed investment (4) other			
	b	Balance at the end of the previous year		7b	
	С	Additions: (1) Contributions deposited during the year	7c(1)		
		(2) Dividends and credits	. 7c(2)		
		(3) Interest credited during the year	. 7c(3)		
		(4) Transferred from separate account	7c(4)		
		(5) Other (specify below)	7c(5)		
		<b>)</b>			
		(6)Total additions		7c(6	) 0
	٦	(6)Total additions and additions (add lines <b>7b</b> and <b>7a(6)</b> )			,
		Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> )			
	е	Deductions: (1) Disbursed from fund to pay benefits or purchase annuities during year	70(1)		_
			7e(1)		
		(2) Administration charge made by carrier	7e(2)		
		(3) Transferred to separate account	7e(3)		
		(4) Other (specify below)	. /e(4)		_
		•			
		(5) Total deductions		7e(5	0
	f	Balance at the end of the current year (subtract line <b>7e(5)</b> from line <b>7d</b> )			

ı	Page	4

8 Benefit and contract type (check all applicable boxes) a	Part I	Welfare Benefit Contract Inform If more than one contract covers the same the information may be combined for repor employees, the entire group of such individ	group of employees of the ting purposes if such conti	acts are exp	erience-rated as a uni	it. Where co	ontracts cover individua	
e	8 Bene	efit and contract type (check all applicable boxes						
e	а	Health (other than dental or vision)	<b>b</b> Dental	с	Vision		<b>d</b> Life insurance	
i	ا م		_ H	=	<u>-</u>	nlovment	_	
9 Experience-rated contracts: a Premiums: (1) Amount received. (2) Increase (decrease) in amount due but unpaid. (3) Increase (decrease) in unearmed premium reserve. (4) Earned ((1) + (2) - (3)). (5) Benefit charges (1) Claims paid. (6) Increase (decrease) in claim reserves. (7) Increase (decrease) in claim reserve. (8) Benefit charges (1) Claims paid. (9) Increase (decrease) in claim reserves. (9) Increase (decrease) in amount of the serves. (1) Increase (decrease) in claim reserves. (2) Increase (decrease) in claim reserves. (3) Incurred claims (add (1) and (2)). (4) Claims charged. (5) Increase (decrease) in claim reserves. (8) Administrative service or other fees. (9) Increase (decrease) in amount of the serves. (1) Increase (decrease) in amount of the serves. (2) Increase (decrease) in amount of the serves. (3) Other reserves at end of year: (1) Amount held to provide benefits after retirement. (2) Claim reserves. (3) Other reserves at end of year: (1) Amount held to provide benefits after retirement. (2) Claim reserves. (3) Other reserves at end of year: (1) Amount held to provide benefits after retirement. (2) Claim reserves. (3) Other reserves at end of year: (1) Amount held to provide benefits after retirement. (2) Claim reserves. (3) Other reserves at end of year: (1) Amount held to provide benefits after retirement. (3) Other reserves. (4) Increase (decrease) in amount of the serves	: [			·	<u>-</u>	рюутст		
Permiums: (1) Amount received	'		I HMO contract	ĸL	PPO contract		I ☐ Indemnity contra	Cī
a Premiums: (1) Amount received	m	Other (specify) ▶STATUTORY DISABILITY						
a Premiums: (1) Amount received								
(2) Increase (decrease) in amount due but unpaid. (3) Increase (decrease) in unearned premium reserve. (4) Earned ((1) + (2) - (3)).  Benefit charges (1) Claims paid. (2) Increase (decrease) in claim reserves. (3) Incurred claims (add (1) and (2)). (4) Claims charged.  C Remainder of premium: (1) Retention charges (on an accrual basis)  (A) Commissions. (B) Administrative service or other fees. (C) Other specific acquisition costs. (D) Other expenses. (D) Other expenses. (D) Other expenses. (D) Other retention charges (F) Charges for risks or other contingencies. (E) Taxes. (C) Other retention charges. (H) Total retention. (2) Dividends or retroactive rate refunds. (These amounts were paid in cash, or credited.) (2) Claim reserves. (3) Other reserves at end of year: (1) Amount held to provide benefits after retirement. (2) Claim reserves. (3) Other reserves at end of year: (1) Amount held to provide benefits after retirement. (2) Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).) (E) Taxes. (D) Other reserves. (D) Other reserves	•		!	0. (4)				
(3) Increase (decrease) in unearned premium reserve		` '					_	
(4) Earned ((1) + (2) - (3))				• • •			_	
b Benefit charges (1) Claims paid (2) Increase (decrease) in claim reserves			•			00(4)		
(2) Increase (decrease) in claim reserves	_				•••••	. 9a(4)		
(3) Incurred claims (add (1) and (2))				• •				
(4) Claims charged						0h/3\		
C Remainder of premium: (1) Retention charges (on an accrual basis)  (A) Commissions								
(A) Commissions 9c(1)(A)  (B) Administrative service or other fees 9c(1)(B)  (C) Other specific acquisition costs 9c(1)(C)  (D) Other expenses 9c(1)(D)  (E) Taxes 9c(1)(E)  (F) Charges for risks or other contingencies 9c(1)(F)  (G) Other retention charges 9c(1)(F)  (H) Total retention . 9c(1)(G)  (2) Dividends or retroactive rate refunds. (These amounts were paid in cash, or credited.) 9c(2)  d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement 9d(1)  (2) Claim reserves 9d(2)  (3) Other reserves 9d(3)  e Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).) 9e  10 Nonexperience-rated contracts:  a Total premiums or subscription charges paid to carrier 10a  b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount 10b		. ,		•••••		. 35(4)		
(B) Administrative service or other fees	Ū		·	9c(1)(Δ)				
(C) Other specific acquisition costs								
(D) Other expenses 9c(1)(D)  (E) Taxes 9c(1)(E)  (F) Charges for risks or other contingencies 9c(1)(F)  (G) Other retention charges 9c(1)(G)  (H) Total retention 9c(1)(H)  (2) Dividends or retroactive rate refunds. (These amounts were paid in cash, or credited.) 9c(2)  d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement. 9d(1)  (2) Claim reserves 9d(2)  (3) Other reserves 9d(3)  e Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).) 9e  10 Nonexperience-rated contracts:  a Total premiums or subscription charges paid to carrier 10a  b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. 10b		( )						
(E) Taxes		( )						
(G) Other retention charges 9c(1)(G)  (H) Total retention 9c(1)(H)  (2) Dividends or retroactive rate refunds. (These amounts were paid in cash, or credited.) 9c(2)  d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement 9d(1)  (2) Claim reserves 9d(2)  (3) Other reserves 9d(3)  e Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).) 9e  10 Nonexperience-rated contracts: 10a  b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. 10b		•						
(G) Other retention charges 9c(1)(G)  (H) Total retention 9c(1)(H)  (2) Dividends or retroactive rate refunds. (These amounts were paid in cash, or credited.) 9c(2)  d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement 9d(1)  (2) Claim reserves 9d(2)  (3) Other reserves 9d(3)  e Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).) 9e  10 Nonexperience-rated contracts:  a Total premiums or subscription charges paid to carrier 10a  b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. 10b		(F) Charges for risks or other contingencies		9c(1)(F)				
(2) Dividends or retroactive rate refunds. (These amounts were paid in cash, or credited.) 9c(2)  d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement 9d(1)  (2) Claim reserves 9d(2)  (3) Other reserves 9d(3)  e Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).) 9e  10 Nonexperience-rated contracts:  a Total premiums or subscription charges paid to carrier 10a  b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. 10b				9c(1)(G)				
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement		(H) Total retention				. 9c(1)(H)		
(2) Claim reserves		(2) Dividends or retroactive rate refunds. (These	amounts were paid in	cash, or	credited.)	9c(2)		
(3) Other reserves	d	Status of policyholder reserves at end of year: (	Amount held to provide	benefits after	retirement	. 9d(1)		
Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).)      Nonexperience-rated contracts:     Total premiums or subscription charges paid to carrier		(2) Claim reserves				. 9d(2)		
10 Nonexperience-rated contracts:  a Total premiums or subscription charges paid to carrier		(3) Other reserves				. 9d(3)		
a Total premiums or subscription charges paid to carrier	е	Dividends or retroactive rate refunds due. (Do r	ot include amount entered	I in line <b>9c(2)</b>	.)	. <b>9e</b>		
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount	<b>10</b> No	nexperience-rated contracts:						
retention of the contract or policy, other than reported in Part I, line 2 above, report amount	а	Total premiums or subscription charges paid to	carrier			10a		263
Specify nature of costs.		retention of the contract or policy, other than rep				. 10b		
		retention of the contract or policy, other than rep				10b		
Part IV Provision of Information	Part I	V Provision of Information						
11 Did the insurance company fail to provide any information necessary to complete Schedule A?			nation necessary to compl	ete Schedule	A?	Yes	X No	
12 If the answer to line 11 is "Yes," specify the information not provided.							<u> </u>	

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

**Service Provider Information** 

File as an attachment to Form 5500.

OMB No. 1210-0110

2017

This Form is Open to Public Inspection.

For calendar plan year 2017 or fiscal plan year beginning 01/01/2017	and ending 12/31/2017	
A Name of plan	<b>B</b> Three-digit	
ZETA ASSOCIATES INCORPORATED INDIVIDUAL BENEFIT ACCOUNT	plan number (PN)	501
	_	
C Plan sponsor's name as shown on line 2a of Form 5500	<b>D</b> Employer Identification Number (	EIN)
ZETA ASSOCIATES INCORPORATED	54-1279046	
Part I Service Provider Information (see instructions)		
Tart Toervice Frovider information (see instructions)		
You must complete this Part, in accordance with the instructions, to report the information or more in total compensation (i.e., money or anything else of monetary value) in conner plan during the plan year. If a person received <b>only</b> eligible indirect compensation for we answer line 1 but are not required to include that person when completing the remainder	ction with services rendered to the plan or thich the plan received the required disclosi	he person's position with the
1 Information on Persons Receiving Only Eligible Indirect Compensation	sation	
a Check "Yes" or "No" to indicate whether you are excluding a person from the remainder	of this Part because they received only elig	ible
indirect compensation for which the plan received the required disclosures (see instruction	ons for definitions and conditions)	Yes X No
<b>b</b> If you answered line 1a "Yes," enter the name and EIN or address of each person prov received only eligible indirect compensation. Complete as many entries as needed (see		e providers who
(b) Enter name and EIN or address of person who provided you	disclosures on eligible indirect compensation	ion
		·
(b) Enter name and EIN or address of person who provided you	u disclosures on eligible indirect compensa	ion
(0) = 110 114110 4.14 = 110 0. 4441000 0. P01001 1110 P1011400 )00	. a.co.coa.co	
(b) Enter name and EIN or address of person who provided you	disclosures on eligible indirect compensa-	ion
(., ,	- and an	
(b) Enter name and EIN or address of person who provided you	disclosures on eligible indirect compensation	ion
(-,		· -

Schedule C (Form 5500) 2017	Page <b>2-</b> 1
(b) Enter name and EIN or address of person wh	no provided you disclosures on eligible indirect compensation
(b) Enter name and EIN or address of person when	no provided you disclosures on eligible indirect compensation
(b) Enter name and EIN or address of person when the contract of the contract	no provided you disclosures on eligible indirect compensation
( <b>b</b> ) Enter name and EIN or address of person where	no provided you disclosures on eligible indirect compensation
(b) Enter name and EIN or address of person when the control of th	no provided you disclosures on eligible indirect compensation
(b) Enter name and EIN or address of person when the contract of the contract	no provided you disclosures on eligible indirect compensation
(b) Enter name and EIN or address of person when the contract of the contract	no provided you disclosures on eligible indirect compensation
(b) Enter name and EIN or address of person when	no provided you disclosures on eligible indirect compensation

	Page <b>3</b> -	1	]	
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answered	I "Yes" to line 1a above	e, complete as many	entries as needed to list ea	r Indirect Compensation of the person receiving, directly or	indirectly, \$5,000 or more in t	otal compensation
(i.e., mone	ey or anything eise or	,		ne plan or their position with the raddress (see instructions)	pian during the pian year. (So	ee instructions).
CIGNA HE	ALTH & LIFE INSURA		(4)			
59-103107	11					
(b) Service Code(s)	Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	(h) Did the service provider give you a formula instead of an amount or estimated amount?
12 38 50 13 49 56 31 62	PROVIDES CLAIM & SERVICES	7182	Yes X No	Yes 🛛 No 🗌	0	Yes X No
	<u> </u>	(	a) Enter name and EIN or	address (see instructions)		<u> </u>
(b) Service Code(s)	Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	(h) Did the service provider give you a formula instead of an amount or estimated amount?
			Yes No	Yes No		Yes No
		(	a) Enter name and EIN or	address (see instructions)		
(b) Service Code(s)	Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	(h) Did the service provider give you a formula instead of an amount or estimated amount?
			Yes No	Yes No		Yes No

Page	3 -	2
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answered	"Yes" to line 1a above	e, complete as many	entries as needed to list ea	r Indirect Compensation ch person receiving, directly or the plan or their position with the	indirectly, \$5,000 or more in t	otal compensation
	, , ,	,		address (see instructions)		,
(b) Service Code(s)	Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	(h) Did the service provider give you a formula instead of an amount or estimated amount?
			Yes No	Yes No		Yes No
		(	(a) Enter name and EIN or	address (see instructions)		
(b) Service Code(s)	Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	(h) Did the service provider give you a formula instead of an amount or estimated amount?
			Yes No	Yes No		Yes No
		(	a) Enter name and EIN or	address (see instructions)		
(b) Service Code(s)	Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	(h) Did the service provider give you a formula instead of an amount or estimated amount?
			Yes No	Yes No		Yes No

Page	4	-	I
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## Part I Service Provider Information (continued)

3. If you reported on line 2 receipt of indirect compensation, other than eligible indirect compen or provides contract administrator, consulting, custodial, investment advisory, investment ma questions for (a) each source from whom the service provider received \$1,000 or more in ind provider gave you a formula used to determine the indirect compensation instead of an amount many entries as needed to report the required information for each source.	nagement, broker, or recordkeepinç lirect compensation and (b) each so	g services, answer the following ource for whom the service
(a) Enter service provider name as it appears on line 2	(b) Service Codes	(c) Enter amount of indirect
	(see instructions)	compensation
(d) Enter name and EIN (address) of source of indirect compensation	formula used to determine	compensation, including any the service provider's eligibility he indirect compensation.
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(C) Enter amount of indirect compensation
(d) Enter name and EIN (address) of source of indirect compensation	formula used to determine	compensation, including any the service provider's eligibility the indirect compensation.
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
(d) Enter name and EIN (address) of source of indirect compensation	formula used to determine	compensation, including any the service provider's eligibility the indirect compensation.

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D( II   O   1   D		No. 20 1 1 1 1 1 1				
this Schedule.	ide, to the extent possible, the following information for each service provider who failed or refused to provide the information necessary to complete Schedule.					
(a) Enter name and E	IN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(C) Describe the information that the service provider failed or refused to provide			
(a) Enter name and E	IN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(C) Describe the information that the service provider failed or refused to provide			
(a) Enter name and E	IN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(C) Describe the information that the service provider failed or refused to provide			
(a) Enter name and E	IN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(C) Describe the information that the service provider failed or refused to provide			
(a) Enter name and E	IN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(C) Describe the information that the service provider failed or refused to provide			
(a) Enter name and E	IN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(c) Describe the information that the service provider failed or refused to provide			

Schedule C (Form 5500) 2017

Pa	Part III Termination Information on Accountants and Enrolled Actuaries (see instructions)				
	(complete as many entries as needed)	L =			
a	Name:	<b>b</b> EIN:			
C	Position:				
d	Address:	<b>e</b> Telephone:			
Fx	planation:				
	prantation.				
а	Name:	b EIN:			
c	Position:	EIII.			
d	Address:	e Telephone:			
-					
Ex	planation:				
а	Name:	<b>b</b> EIN:			
С	Position:				
d	Address:	<b>e</b> Telephone:			
	planation:				
LX	pianation.				
а	Name:	b EIN:			
C	Position:	D LIIV.			
d	Address:	e Telephone:			
Explanation:					
a	Name:	<b>b</b> EIN:			
C	Position:				
d Address:		<b>e</b> Telephone:			
	planation				
ĽΧ	Explanation:				